FI 40B 6/2001
Division of Finance

See detailed instructions on page 2 of this form.

Employee Name: _____ Title: _____

Employee Number: _____ Payroll Period: _____

Agency Code: 270 Low Org: _____ Dist.: _____

PRIVATE VEHICLE USAGE REPORT FOR REIMBURSEMENT AT .345 PER MILE

Date (mm/dd/yy)	From (location)	To (location)	Beginning Mileage	Ending Mileage	Miles Driven	Fund	Agency	Low Org	Approp Unit	Activity	Reptg Catg	Project/ Job	Business Purpose of Miles Driven	*
				Total Miles		X $.345 =								

Total Amount (DOE 09)

I hereby certify that this mileage was incurred on official State business and that the amounts are correct and proper.

* Reason(s) for reimbursing at .345 cents per mile:
1 - State fleet vehicle not available
2 - Time required to obtain state vehicle not cost effective
3 - Short distance to drive but ties up vehicle all day
4 - State fleet vehicle not available that meets program needs
5 - Other - Attach documentation

Signature of Traveler

Date

Dept. of Health
Agency Name

Division

Reviewed and Approved - Agency Head/Immediate Supervisor Signature

Payroll Clerk - Initial and Date